Authorization for Access/Release of Information

NAME: ____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _________ __________ ___________
MONTH DAY YEAR

ADDRESS:____

CITY:____ **STATE:** ________ **ZIP**:________________

DAY PHONE:_________________________ **EVENING PHONE**: ____________________________________

I hereby authorize Health Assistance interVention Education Network for Connecticut Health Professionals (HAVEN) **and related entities to**:

☒ **release information from my record to:** ☒ **obtain information from:**

ORGANIZATION NAME: ________________________________ CONTACT NAME: ________________________

ADDRESS:____

CITY:____ STATE:________ ZIP:__________________

PHONE: ____ FAX: ____________________________________

PURPOSE OF DISCLOSURE: (*Required)*

☐ Evaluation/Treatment
☐ Case Management Coordination
☒ At Patient's Request
☐ Other (please specify)

INFORMATION TO BE RELEASED/OBTAINED: (***Required. Please check all appropriate boxes.)***

☐ Psychiatric Evaluation/Consultations
☐ Medical History and Physical Exam
☐ Progress Notes
☐ Discharge/Transfer Summary
☐ Psychological Evaluation
☐ Medication Records
☐ Treatment Plans
☐ Biopsychosocial History/Assessment
☐ Laboratory Results
☐ Other (Please specify):_________________________________

DATES OF TREATMENT COVERED BY THIS REQUEST: (*Required)*

☐ All prior episodes of care, through discharge from present episode of care
☐ Limited to the following date(s): ____

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified: ___________
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health, substance abuse or HIV/AIDS-related information, pursuant to C.G.S. sections 52-146d through 52-146i, C.G.S. 19a-585 and C.G.S. 19a-126h, unless otherwise specified:

   ☐ No Mental Health ☐ No Substance Abuse ☐ No HIV/AIDS

____________________________________ ______________________________
Signature of Patient/Participant Date

____
Print Name

____________________________________ ______________________________
Parent/Legal Guardian/Authorized Person Date

____
Relationship to patient/participant

A COPY OF THIS FORM MAY BE RECEIVED AFTER SIGNING